

A Qualitative Content Analysis of Online GP Reviews in Norway

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Abstract

BACKGROUND: The last decade has seen exponential growth in the use of physician rating websites (PRWs), particularly in the US and the UK. In contrast to traditional survey methods, the reviewers on PRWs voluntarily seek out such websites and leave anonymous, public reviews in a somewhat interactive environment. In 2012, Legelisten.no became the first PRW in Norway, inviting Norwegian patients to leave star-ratings and free-text comments reviewing their GPs (*fastleger*).

AIM: The aim of this study was to investigate the issues that reviewers on Legelisten.no bring up in describing their satisfaction or dissatisfaction with their GP, and how these issues are explored across the range of sampled reviews. The focus was on what GPs and researchers can learn from the reviews and their common themes.

METHOD: A qualitative content analysis was carried out on the free-text comments from 120 randomly sampled GP reviews collected from Legelisten.no. The data was first translated from Norwegian to English. Following a strategy of directed content analysis, a trial coding was carried out on a select number of reviews using an initial codebook of a priori themes, with a final codebook developed during the entire coding process. The codes and their associated quotations were then examined for underlying themes. A brief analysis of frequently occurring words was also conducted.

RESULTS: Reviewers focused on the GP and the consultation, where they valued personality factors, interpersonal skills, emotional support, an established relationship, and perceived technical competence. Customer service and availability were valued in receptionists and the clinic. Unexpected themes included how GPs handle the reviewers' mental and psychological struggles. Reviewers demonstrated doctor-shopping tendencies consistent with the rise of healthcare consumerism, although doctor-patient loyalty was also present. The online, public nature of the reviews was seen in the reviewers' awareness of an audience, their interaction with previous reviews, and the timing and purpose of their review.

CONCLUSION: The results were consistent with previous studies which have shown that patients most value personality factors and interpersonal aspects of the GP and their consultation, along with perceived technical competence. However, the results may not be generalizable to the wider Norwegian population.

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1 Introduction

The role of the internet in health and healthcare has expanded exponentially over the last decade. One aspect of this is online user reviews of primary care physicians, or general practitioners (GPs), with the number of physician rating websites (PRWs) and reviews increasing rapidly in recent years. For instance, the number of Americans using the internet to search for health information rose from 25% in 2000 to 61% in 2008, with the majority of those using the internet for this purpose (60%) accessing ‘user-generated’ information (Lopez, Detz, Ratanawongsa, & Sarkar, 2012, p. 685). More specifically, a 2011 study of internet users in the US found that 16% of internet users, or 12% of all adults, have consulted online rankings and reviews of physicians or other providers (Fox, 2011). While there is evidence that physicians themselves show some concern for the growing popularity of PRWs and the potential for negative reviews to influence current and prospective patients (Shannon, 2013), the existing literature suggests there remains merit in online physician reviews. In their study of the relationship between online user reviews and conventional measures of patient experience through paper-based NHS surveys, Greaves et al. (2012, p. 604) found that online ratings were relevant, complementary to survey data, and valuable for other patients choosing health care providers.

Most research on online reviews of healthcare providers has focused on the US and the NHS system in the UK, but the potential insight for Norway is significant given the nature of primary care in Norway. In 2001 the Norwegian government introduced the regular GP scheme, in which members of the National Insurance Scheme can voluntarily assign themselves to a GP of their choice (Godager, 2012). By allowing patients to select their own GP and moreover giving them the opportunity to change GPs biannually, this scheme emphasizes the importance of patient satisfaction with their GP. As PRWs are gaining popularity and media attention in Norway, it is likely they will become a more central part of patients’ choice of GP.

Norway’s primary PRW, Legelisten.no, was launched in May 2012 and includes ratings for all GPs in Norway. The website now has more than 10,000 anonymous GP reviews from patients, which are moderated to some extent to exclude allegations of improper treatment or diagnosis, and second-hand opinions on the GPs in question. On the site, users rate GPs out of 5 stars for availability, trust and communication, service, and an overall rating, again out of 5

stars. Each reviewer also has room for free-text comments on their experience with their GP (Legelisten, 2013).

Although studies have found that the majority of patient reviews on PRWs are positive (Ellimoottil, Hart, Greco, Quek, & Farooq, 2012; Lopez et al., 2012), there is nevertheless much to be learned about patient needs and satisfaction from the issues raised by users. This study will be in the same vein as that by Lopez et al. (2012), who conducted a qualitative content analysis of online reviews for primary care physicians in the U.S. The study found that: the majority of reviews were positive; there was a difference between the ratings in global reviews, and between specific descriptions which include the GP's interpersonal manner, technical competence, and systems-issues (Lopez et al., 2012, p. 685). Using qualitative content analysis, this study will endeavour to provide similar insight into online GP reviews written by Norwegian patients.

1.1 Aims of the study

The aim of the study is to use qualitative content analysis of online GP reviews in Norway to investigate how reviewers (patients) describe their experiences with their GP, and to identify the issues they focus on in expressing their satisfaction or dissatisfaction. The focus will be on what Norwegian GPs can learn about patient preferences and attitudes from the free-text comments of unsolicited online reviews. These insights could be used in improving patient experience and satisfaction with primary care in Norway, as well as contribute to our growing understanding of PRWs within an international context and their role as another mode of patient feedback.

2 Theory and existing literature

2.1 Patient satisfaction and experience

Like other forms of patient feedback, online GP reviews are directly linked to the concept of patient satisfaction. Patient satisfaction is roughly defined by Linder-Pelz (1982, p. 578) as “positive evaluations of distinct dimensions of the health care [being evaluated]”. Over the last few decades, patient satisfaction has come to be seen both as an important measure of the quality in healthcare (B. Williams, 1994), and as a goal in the delivery of healthcare in itself (Linder-Pelz, 1982).

However, both ‘satisfaction’ and constructs associated with patient satisfaction are difficult to measure, and it is partly due to this that such studies are increasingly focusing on ‘patient experience’ rather than ‘patient satisfaction’ (Bleich, Özaltin, & Murray, 2009). Patient experience can be defined as “the sum of all interactions, shaped by an organization’s culture, that influence patient perceptions, across the continuum of care” (Wolf, Niederhauser, Marshburn, & LaVela, 2014, p. 8). Another reason for this shift is that studies which set out to measure patient ‘satisfaction’ may limit their results – including the responses of any participating patients – to the expression of satisfaction or dissatisfaction, rather than capturing the many aspects involved in a positive or negative patient experience. Given the fact that online GP reviews deal explicitly with the expression of satisfaction and dissatisfaction, generally through prompts exploring different facets of the GP and their clinic, much of the literature I will cover here will be regarding patient satisfaction. Before delving further into patient satisfaction, I will first make mention of perhaps the most comprehensive studies on patient experience in the Norwegian setting.

In recent years, the Norwegian Knowledge Centre for the Health Services has published annual reports on national surveys regarding patient experiences in somatic hospitals in Norway. Of course, factors that affect patient experience may differ greatly between hospitals and primary care, due to the vastly different structures and processes of the two environments. Additionally, along with the general differences in the nature of the two experiences comes differing health states – conditions serious enough to warrant a hospital visit vs. those requiring a GP visit – which may also result in different patient expectations and experiences. Yet some general themes can carry over from these reports, particularly those regarding

interaction with various staff at the hospital (not just physicians but also nursing and administration staff). For instance, survey questions about the patients' experiences with their doctors and nursing staff during their hospital visit focus on a number of interpersonal factors, including whether or not they felt that their doctors and nurses had time for them, were interested in their situation, and cared about them (Bjerkan, Holmboe, & Skudal, 2014). Some other questions covering information (for example, "Did you receive adequate information regarding your diagnosis/problems?") would also be relevant in a primary care setting, while others would be less applicable (for example those covering hospital visits from relatives) (Bjerkan et al., 2014). As I will now explore, a number of these are factors have also been seen to strongly influences measures of patient satisfaction in primary care.

Constructs which contribute to patient satisfaction include: accessibility/convenience, availability of resources, continuity of care, efficacy/outcomes of care, finances, humaneness, information gathering, information giving, pleasantness of surrounding, and quality/competence (Linder-Pelz, 1982, p. 578). These constructs can be difficult to measure due to the fact that some capture subjective and intangible aspects of patient-physician interactions, such as humaneness, rather than quantifiable dimensions such as opening hours. Additionally, studies on their contributions to patient satisfaction levels can be difficult to compare due to discrepancies between measurement methods and metrics, and even within a single study there can be challenges and inconsistencies in measurements due to the subjective nature of that which we attempt to measure. In one study by Mead and Bower (2000), the authors noted that analysis of video-taped GP consultations was hampered by the research team's different interpretations of nuanced behaviours.

These difficulties at the research level are particularly problematic for the health care industry, as the most intangible aspects of care have often been found to be those that contribute most to patients' satisfaction levels. For example, one Norwegian study found that the majority of patients studied had a strong preference for shared decision-making in consultations with their GPs, and such a preference in the GP had a positive effect on the patients' satisfaction (Carlsen & Aakvik, 2006, p. 148). These findings are also reflected in similar studies on patient preferences for shared decision-making in the UK (Schattner, Bronstein, & Jellin, 2006). Other studies show that a patient's trust and confidence in their GP is the most important variable in explaining their overall satisfaction, and variables connected to the physician-patient relationship have a stronger explanatory power than those variables

relating to the clinic itself, such as waiting times (Robertson, Dixon, & Le Grand, 2008, p. 70). The overarching theme from previous research is that the softer, interpersonal factors encompassed in the doctor-patient relationship are most important to patients.

Other studies have focused on the distinction between patient expectations and patient satisfaction, and how these interact with one another. Research has shown that patients who report that a high number of their pre-consultation expectations were met also show significantly higher levels of satisfaction post-consultation (S. Williams, Weinman, Dale, & Newman, 1995, p. 193). Some researchers even suggest that patient satisfaction is determined by negative expectations as much as positive expectations – that satisfaction will be expressed as long as no socially unacceptable behaviour is demonstrated by the GP (B. Williams, 1994, p. 514). Indeed, a study by Nelson and Larson (1993) on the effect of ‘good surprises’ and ‘bad surprises’ on satisfaction levels found that the majority of patients who reported ‘no surprise’ also expressed satisfaction, and those who reported a ‘bad surprise’ were more likely to express dissatisfaction.

The influence of demographic variables on satisfaction levels also cannot be ignored. Satisfaction has been found to be positively related to the age of the patient (S. Williams et al., 1995, p. 513), which may be due to the traditionally passive role of the patient often still embodied by older patients, in contrast to the “consumerist oriented role” adopted by younger patients (p. 514). As Legelisten.no does not reveal the age or demographics of all of the reviewers on its site, these influences cannot be accounted for in this study, whose intention is in any case to discover the most important variables to patients as a whole. This factor is nevertheless worth mentioning as some reviewers may reference their own characteristics in explaining their satisfaction or dissatisfaction with their GP. Additionally, it could aid us in understanding possible attitudes and perspectives behind the issues brought up in different reviews.

Finally, researchers have also found that not only is the age of the patient a predictor of patient satisfaction with a consultation, but so is the length of the consultation and the patient’s level of acquaintance with their GP (Mead, Bower, & Hann, 2002, p. 293). In terms of online patient reviews, the predictive power of the length of the consultation can be seen as coupled with patient’s concerns about their physician being too busy, as busier physicians often have less time for each consultation. The last factor, the level of GP-patient acquaintance, could show a certain ‘halo effect’, which Mead et al. (2002) suggest could

mean that evaluations are “based more on familiarity and overall liking for the doctor than specific consultation processes” (p. 295).

2.2 Patient-focused care

In a broad sense, ‘patient-focused care’ is an approach to the provision of healthcare services that seeks to improve those aspects of the healthcare experience that are important to patients, using an understanding of patient needs as a basis for changing the operational processes of healthcare (Irwin & Richardson, 2006; Lathrop, 1993). Patient-focused care – also referred to as ‘patient-centred care’ or ‘patient-centredness’ as a general concept – often involves an emphasis on the more intangible factors in a patient’s interaction with a healthcare organization or a healthcare provider, such as communication and a sense of partnership with their physician (Irwin & Richardson, 2006). It has variously been conceptualized as a professional attitude, a set of knowledge, and as a set of consultation behaviours (Mead & Bower, 2000, p. 72).

The relevance of patient-focused care is supported by studies on patient expectations of and satisfaction with their GP, which have found that patients typically place the most importance on doctor-patient relationships (Robertson et al., 2008; B. Williams, 1994). Indeed, as mentioned above, relationship factors have been shown to have a greater impact on patient satisfaction than factors such as the process and difficulty of making an appointment, or their experience in the waiting room (Robertson et al., 2008). Given this, I would expect the online patient reviews to focus on aspects identified as important within models of patient-focused care. PRWs can thus be seen as tools to further understand patient needs in primary care, particularly within the context of a shift towards patient-centredness within healthcare services.

While there is no strict agreement between researchers on the operationalization and measurement of patient-focused care, there are some clues to be found in the research that can be useful in understanding how the concept may tie into online reviews by patients. In their comparison of observation-based instruments for measuring patient-focused care, Mead and Bower (2000) used a rating scale of physician behaviours to aid in their analysis of GP consultations. They included markers such as whether the physician: involved the patient in

defining the reason and the expectations for their visit; involved the patient in decision-making regarding management of the problem (an aspect that we have seen features often in studies on patient satisfaction); picked up cues from the patient about undisclosed or unresolved aspects of the problem; explored the issue of patient ambivalence and self-efficacy; and whether the physician demonstrated a level of overall ‘responsiveness’, such as listening and responding appropriately throughout the consultation (Mead & Bower, 2000, p. 74). Some of these behaviours may be discussed more generally in online patient reviews, perhaps coming under a wider umbrella of whether or not the patient felt that their physician listened to them. Still, an understanding of the possible nuances behind such general statements – and perhaps more pointed references – can help us to understand where physicians could improve in expressing patient-centredness.

2.3 Consumerism in healthcare

Both patient satisfaction and patient-focused care can be linked to the development of consumerism in healthcare—where the satisfaction of the patient is considered essential regardless of the efficacy of their treatment (B. Williams, 1994, p. 577), provider competition is promoted, and the patient is seen as a rational consumer encouraged to make their own decisions regarding cost and quality (Robinson, 2005). In this light, PRWs and their featured patient reviews can be seen as a tool for the patient, as consumer, to make a more informed decision when choosing their GP, as a provider in the healthcare industry. I would therefore expect the issues raised by the reviewers to also include service aspects that reflect the roles of customer and business as well as patient and physician.

What McDevitt (1987) referred to as “Doctor Shopping” behaviour (p. 50) has become increasingly prevalent among patients, particularly those in the younger generations, who you will recall were also less likely to report satisfaction than elderly patients. Moving away from the “dependent patient” model of the past, McDevitt describes the first waves of change in the late 1970s and 1980s as a time when “health care consumers began to behave like dissatisfied consumers rather than like patients” (p. 49). In their study, Lloyd, Lupton and Donaldson (1991) refer to healthcare consumers using a neoclassical economic definition of the consumer as “a person who purchases a good or service *and* who is actively assertive, critical and prepared to shop around for the best deal – in other words, a ‘consumerist’ rather than merely a consumer” (p. 194). It is in this sense that I use the term ‘doctor-shopping’, to

include patients engaging in behaviours typical of an active healthcare consumer ‘shopping around’ for the best GP. This aspect is important to note, as doctor-shopping can also refer to visiting multiple health professionals in order to illegally obtain prescription medications (Sansone & Sansone, 2012). With this understanding, PRWs are both a product of healthcare consumerism, and its facilitator. They stimulate and encourage patients to reflect on their encounters with their GP in an inherently critical way, and provide a resource for other patients to use in their “Information Search” (McDevitt, 1987), a key stage in the marketing process that now applies to health care. And of course, they provide fruitful ground for research into the desires and expectations of primary care patients as consumers.

While the landscape of American healthcare differs in many ways from the Norwegian model, subtle shifts towards a more competitive healthcare market can be felt in Norway, in for instance: the gradual growth of private health insurance in Norway; worries that rising healthcare costs will lead to creeping privatization of the sector (Veggeland & Høgskolen i Lillehammer, 2013); and indeed, in the birth and growth of Legelisten.no. According to figures released by Finansnæringens Fellesorganisasjon, the number of Norwegians covered by private health insurance has increased by 15% since 2012, to 380,000, also a full twelve times higher than in 2003 (Johannessen, 2014, February 9). While the vast majority of those covered are covered through their employer and often for specialist services (Johannessen, 2014, February 9), the growth of this market is still significant. Combined with the right to change GP biannually and the introduction of Legelisten itself, this arguably speaks to a change in which healthcare in Norway is increasingly subject to similar consumer demands as other industries.

There may be some tension between healthcare consumerism and the emphasis on ‘softer’ interpersonal relationships between patients and caregivers found in both studies on patient satisfaction and the framework of patient-focused care. Studies have shown what a high value many patients place on interpersonal skills and a general understanding between the patient and their GP, but are these needs incompatible with healthcare cultures in which patients are encouraged to pick and choose and review their GPs in the same way that they do a new electronic purchase? Despite the emphasis on the patient-doctor relationship, some studies have shown that a majority of participating patients value technical competency to an equal or greater extent than interpersonal skills (Fung et al., 2005). From certain perspectives there can be seen to be tensions too between a modern model of health care consumerism and a

traditional model of long-term doctor-patient relationships characterized by trust and dependency (Lloyd et al., 1991, p. 194). This tension warrants further exploration in the study.

2.4 Online physician reviews

While Legelisten.no was launched in 2012 and thus far remains the only PRW in Norway, studies have identified dozens of such sites in the US, and RateMDs.com, one of the largest PRWs in the US, was created in 2004 (Gao, McCullough, Agarwal, & Jha, 2012). PRWs were originally an initiative by private companies such as health insurers, however governments have begun to recognize the value of this method of feedback – the British National Health Service (NHS) introduced their NHS Choices website in 2008, which not only allows but actively encourages patients to review and rate their experiences with their health care providers using both a quality rating scales and free-text comments (Greaves et al., 2012). Some posit that reviews on private sites such as those run by health insurance companies might be more likely to attract (or display?) positive reviews than those run by the public sector (Greaves et al., 2012).

While the proliferation of PRWs, bringing with it a new level of transparency and accountability to healthcare interactions, does not come without controversy, the overall trend seems to be towards a new legitimacy. Concerns have been raised by physician groups (including the American Medical Association) as to the legality, ethicality, and potential professional dangers lurking in PRWs, particularly in the US (Lagu, Hannon, Rothberg, & Lindenauer, 2010). Opposition is so widespread, in fact, that Marciarille (2012, p. 362) calls the movement “an entire industry of physician internet reputation defenders”. Some PRWs accept only anonymous reviews, while others, such as Angie’s List in the US, do not allow them, and actually encourage physicians to respond to their reviews (Marciarille, 2012). PRWs are, after all, “repositories of reputational information” (Marciarille, 2012, p. 376), a valuable commodity in increasingly consumerist healthcare systems. Despite this opposition from physician groups, healthcare consumerism and rising research interest in online reviews from legitimate authorities such as government agencies mean that PRWs are likely here to stay.

A key factor in the acceptance of PRWs as a valuable source of information on patient experiences is the idea that voluntary user-generated reviews online allow a different perspective than traditional survey methods (Marciarille, 2012). In contrast to patient satisfaction surveys, for instance, which often ask the patient to respond to a select group of carefully developed questions on different matters of interest, PRWs can offer a certain freedom for their users. Online reviews and ratings are still organized and prompts are often included to aid in the user's reflective process, but to a large extent patients are able to bring up issues that are most important and relevant to their expectations and experiences. This may be especially valuable for patients, as some healthcare consumers prefer the anecdotal, experience-based information available on PRWs to traditional assessment instruments (Marciarille, 2012, p. 370). And while physician advocacy groups may emphasize the dangers of what we know to be the minority of bad reviews, there is also of course the perspective that a single online review is less valuable on its own, and for what it says about an individual physician, than for what can be learned from aggregated reviews about a group of patients' views on quality of care, and their wants and needs from physicians in general (Marciarille, 2012, p. 401). The information to be found has the potential to benefit actors on all levels of healthcare -- policy-makers, healthcare organizations (including organizational learning [Greaves et al., 2012]) individual physicians, and patients not only in the traditional sense, but also patients as informed consumers. While associations between online GP reviews and independent measures such as clinical quality are still under debate, PRWs can be simply another lens through which to view primary care (Greaves et al., 2012, p. 1).

Much of the existing literature on PRWs comes from the US, and many previous studies include physicians of all medical specialties, not just GPs. This is a significant point of difference, as studies have shown the importance of continuity of care in GP-patient relationships (Detz, López, & Sarkar, 2013), whereas patients may only come into contact with a particular specialist a handful of times. Arguably, increased frequency of interaction and the simple fact that a patient has made a choice to remain with one GP over the long-term would influence both the patient's desire to voluntarily write an online review of the physician, and the content and nature of that review. Particularly because as noted in the previous section, a patient's level of acquaintance with their GP has been found to be a predictor of patient satisfaction (Mead et al., 2002, p. 293), and long-term patients are more likely to write a positive review (Detz et al., 2013).

However, one study found that while GPs had one of the highest average online ratings for quality in the sample, the difference between the quality ratings of sampled specialties was not significant (Gao et al., 2012, p. 9). The same study also shows that of the PRW-rated physicians included in their sample, obstetricians/gynecologists were most likely to have been rated online, while primary care physicians trailed in fourth place, with 16.25% of physicians having received an online rating (Gao et al., 2012, p. 7). In short, it is difficult to say what other effects the inclusion of other physicians may have on our understanding of the literature and previous findings regarding primary care physicians, but it should be noted when drawing comparisons or conclusions using this data.

Additionally, although Legelisten.no does not make details of its users public and this factor can therefore not be included in the study, it is important to again note that there is much we do not yet know about the demographics and motivations of patients posting reviews on PRWs. While the topic requires more research, relevant studies in other countries such as Germany have already shown that rating patients were most often female, between 30-50 years of age, and covered by state rather than private health insurance (Emmert & Meier, 2013, p. 1). While the gender of the rater does not seem to affect the ratings they give, older patients were more likely to give positive ratings than younger patients (Emmert & Meier, 2013, p. 1), which is consistent with studies mentioned in the previous sections that show older patients are more likely to expression satisfaction. Despite the current lack of information on Legelisten.no's demographics, it is still possible that the age and/or gender of the rating patient may be mentioned anecdotally by the patients themselves. In this event it would be interesting to see how this interacts, if at all, with other codes and themes identified.

3 Methods

3.1 Design

I conducted a qualitative content analysis of online patient reviews of primary care physicians – GPs or *fastleger* in Norwegian – practicing in Norway. My process of inquiry was informed by the eight stages of qualitative content analysis described by Zhang and Wildemuth (2009): prepare the data; define the unit of analysis; develop categories and a coding scheme; test the coding scheme on a sample of text; code all the text; assess coding consistency; draw conclusions from the coded data; and report methods and findings.

Although Legelisten.no now also includes patient reviews of dentists, I chose to focus only on primary care physicians, mostly to allow for greater comparison with previous studies in other countries which often focus on online primary care reviews and physicians in general.

Additionally, for most adults over 20 years of age dental care in Norway is a wholly out-of-pocket expense, in contrast to state-subsidized primary care, and so by assumption is subject to different patient expectations.

3.2 Sampling

The reviews were obtained from Legelisten.no and selected through random sampling. The website's functionality offered me two choices for sampling: to 'browse' the website by selecting categories and filters through which to find and view groups of GPs, clicking through to specific GPs to view their reviews; or to search for a specific GP's name and view all reviews for that particular GP. As the latter would involve targeting certain GPs by name and lead to obvious sampling biases, I decided to randomly sample GPs and their reviews by exploring the browsing options.

At the time of sampling, there were 4,503 GPs listed on Legelisten.no for all of Norway. Using the browsing function on the website, GPs can be separated into 19 geographic regions (many of the most populous cities and municipalities in Norway) or listed together regardless of location. It is also possible to sort all GPs on the website according to different criteria: average overall star rating; alphabetically by GP's last name; the GP's clinic; more specific geographic areas; and number of available places on the GP's list. Finally, there are optional

filters for: gender of the GP; age range of the GP; availability; medical specializations (for example geriatrics or lung disease); and any additional expertise (for example aviation medicine) (Legelisten, 2013).

I decided to sample from all of Norway, with no geographic restrictions or targets. Although sampling from all regions likely meant that the sample is not representative of the demographics of Norway – given the vast population difference between Oslo and Larvik, for instance – the aim was to ensure that reviews outside Oslo were included, and perhaps offered a breadth to the sampled reviews. No other filters or sorting were applied to the total list of GPs, as any of the options would have been more likely to lead to selection bias.

As mentioned, I originally based my study on that by Lopez et al. (2012), who reported reaching thematic saturation after coding around 100 reviews. From this I decided to initially sample 120 reviews, in order to leave a margin. However, sampling continued until thematic saturation was reached. If thematic saturation had not been reached at 120 reviews, the sampling and coding process would have continued until I achieved thematic saturation.

The sample was randomly selected by choosing the option to view all GPs listed on Legelisten.no, sorted alphabetically by last name. I had initially wanted to select every 10th GP on the list to sample from, but at the time of sampling (September 2014), the website's browsing options actually displayed only a maximum of 1,000 GPs – 100 pages of 10 GPs – rather than the full 4,503 featured on the website. This restriction combined with the alphabetical sorting meant that only GPs with last names ranging from A to F were able to be chosen. In order to systematically collect at least 120 reviews, I instead selected every 7th GP on the list, and from this GP I selected the most recent review for inclusion in my analysis. If a selected GP had no reviews, I moved on to the next GP, and resumed counting from there. I chose to select only one review from each GP in the hopes that this would result in greater diversity in the reviews, given different doctoring styles and clinics. Reviews posted between May 2012, when the site opened, and September 2014 (inclusive) were eligible for selection.

3.3 Translation of the text

At the time of translation I was in the process of completing Level 3 Norwegian at the University of Oslo, and so translated the free-text comments from the selected reviews myself. A second translator, wholly fluent in English and a native Norwegian-speaker, was consulted on any comprehension or translation problems during the course of the translation process.

To ensure that my language skills were sufficient, I first conducted a trial translation with ten of the selected reviews. The same native Norwegian-speaker also translated the same ten reviews independently – neither myself nor the second translator read the other’s translations before both groups of translations were finished. The two independent trial translations were then compared to check for accuracy, both in a general sense and in interpreting specific words, and my translations were additionally checked by the second translator.

The trial showed that my own translations were deemed sufficiently comparable to those done by the native speaker. Where variations occurred, they were almost entirely involving synonyms that each held roughly the same meaning. Idiomatic expressions, words from dialects, and occasional writing or typing mistakes were of most difficulty for me to translate, but these were rare, and were able to be resolved through language resources and consultation with the second translator. There may still be limitations in this method of translation, and they will be addressed in the discussion.

Given that my language skills were sufficient to understand and translate the reviews into English, coding might have been possible without translation, while the reviews were still in Norwegian. However, in a study of this nature, I felt that the benefit of dealing with the text in my native language would outweigh any limitations or use of time associated with the translation process. For example, finding patterns within the text and connecting concrete statements to abstract ideas and themes is easier in your native language. Essentially, translating the reviews to English helped me to find the ideas and values that lay behind what was literally being said, and connect them to broader themes.

Finally, the entire translation process also required multiple readings and an immersion in the data that is recognized as an important first step in the process of analysis, as it “helps identify emergent themes without losing the connections between concepts and their context” (Bradley, Curry, & Devers, 2007, p. 1761).

3.4 Directed content analysis

Qualitative content analysis is widely used in qualitative research as a “flexible method for analyzing text data” (Hsieh & Shannon, 2005, p. 1277), encompassing not just one method but a whole “family of analytic approaches ranging from impressionistic, intuitive, interpretive analyses to systematic, strict textual analyses” (Hsieh & Shannon, 2005, p.1277). Hsieh and Shannon (2005) define qualitative content analysis as “a research method for the subjective interpretation of the content of text data through the systematic classification process of coding and identifying themes or patterns” (p. 1278). In recent years the method has become increasingly popular in health research (Nandy & Sarvela, 1997), often in nursing research. It is a method that lends itself particularly well to the analysis of free-text available in the answers to open-ended questions, such as those found on surveys and in online forums.

Hsieh and Shannon (2005) identify three types of content analysis that differ in their coding schemes and origins of codes (p. 1277). In this study I used directed content analysis, in which theories and relevant existing research are used to inform the codes and themes initially used in analysis (Hsieh & Shannon, 2005, p. 1277), and findings from the study are hoped to build on this existing knowledge base. This approach is most appropriate for the study due to the body of literature available on the topic and related topics, some of which I have summarized in the theory section of this paper.

3.4.1 Unit of analysis

Themes were used as the basic unit of analysis in this study (i.e. the basic unit of text that will be classified) (Zhang & Wildemuth, 2009). Boyatzis (as cited in Fereday & Muir-Cochrane, 2006, p. 83) defined a theme as “a pattern in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon”. Themes can be expressed in a number of physical linguistic units, be it a single word, a sentence, or a paragraph, and a code was therefore assigned to any section of text that expressed an idea represented in a theme relevant to the study. These themes were developed both a priori, and during the process of inductive coding and analysis.

3.4.2 Deductive and inductive reasoning

My content analysis used both deductive and inductive reasoning. Thorne (2000) explained the two reasoning processes thusly: "...inductive reasoning uses the data to generate ideas (hypothesis generating), whereas deductive reasoning begins with the idea and uses the data to confirm or negate the idea (hypothesis testing)" (p. 68). Due to my prior research into relevant theories and studies, my analysis was concerned both with exploring how ideas from the literature were evident in the data I collected (deductive), and with examining the data to find recurring themes and patterns independent of pre-existing theories (inductive). Deductive reasoning was part of the process of directed content analysis – and to some extent the analysis and interpretation of my results – while inductive reasoning was still the greater focus of the coding process – ‘inductive coding’ – as well as the analysis and interpretation.

3.4.3 A priori themes

When used appropriately, the identification of a priori themes may save time as they allow for broad coding work to be done earlier on in the process of analysis. As I used directed content analysis and therefore require early direction, a priori themes were developed alongside my initial codes (taken from Lopez et al. [2012]) to help guide my early readings of the sampled reviews. These themes include factors which have been found to be associated with patient health outcomes, such as the patient’s perception of their GP’s friendliness and empathy. The themes were also informed by my preparatory research and the theory section of this paper, in understanding the issues aired by patients on PRWs in other countries, and in general conclusions about the wants and needs of primary care patients. Table 1 lists these a priori themes.

3.4.4 Frequently occurring words

Additionally, a program designed to list word frequencies within a text (Word Counter) was used to discover which meaningful words were used most often in the sampled reviews. Words or phrases of notable frequency were explored and considered relevant for the content analysis, perhaps as a separate theme, but certainly for a separate section in the results to complement the thematic analysis. This borrows from summative content analysis (Hsieh & Shannon, 2005).

Table 1 A priori themes

Theme	Description
Established relationship	Reviewers who have been with their GP for some time and/or who feel they have developed a relationship with their GP
Consumerism	Reviewers actively “doctor-shopping”, warning the reader of a GP, or referencing concerns or behaviours commonly associated with consumerism
Being heard	Whether or not reviewers feel that their GP listens to them, hears their concerns, and takes them seriously
Participation	Reviewers reflecting on whether or not they feel their GP treats them as active participants in making decisions about their health and treatment
Technical competence	Reviewers’ perception of their GP’s clinical abilities, for example to praise or malign it, either for specific instances or their general impression
Personality factors	Reviewers observing their GPs’ positive or negative personality traits, for example friendliness or a tendency to be brusque
Comparison	When a reviewer compares a certain GP to previous doctors they have encountered
Convenience	General ease (or lack thereof) before and after the consultation, for example booking a consultation for a convenient time, parking at the offices, or whether waiting times are reasonable

3.5 Coding

In qualitative content analysis, codes (essentially labels) are assigned to segments of text to “help catalogue key concepts while preserving the context in which these concepts occur” (Bradley et al., 2007, p. 1761). A codebook (or coding manual or scheme), detailing codes/categories and their definition and use, is recommended to ensure consistency in coding (Zhang & Wildemuth, 2009). My coding process was guided by a number of studies, including the aforementioned stages set out by Zhang and Wildemuth (2009), as well as Fereday and Muir-Cochrane (2006).

Drawing on the methods used by Lopez et al. (2012), I gathered several codes that conceptualized the process of a GP visit into three discrete steps. Using these codes and the a priori themes I identified, I developed an initial codebook to be used as an early guide while coding the data. In line with the my focus on inductive inquiry, this codebook changed as the coding process continued to reflect new themes that emerged from the text. As new themes

were identified they either found a place among the existing themes – that is, as part of a hierarchy or group – or stood alone.

The emphasis during the coding process was to develop analytic codes rather than simply descriptive codes. In other words, to work towards codes that reflect the way in which the patient has thought about and conceptualized their experience or the issues they mention, rather than simply using codes that describe what has happened (Gibbs, 2007, p. 43). To begin with, the initial codebook consisted of mostly descriptive codes, in order to give some guidance to the coding process while still allowing for inductive coding. Some of these codes were arranged hierarchically to represent the relationship between metacodes and subcodes. The initial codebook can be found in Table 2.

I used this preliminary codebook for a trial code of 20 of the sampled reviews. This trial allowed me to check whether or not the codes I had developed fit the data, and to make any necessary changes before I began coding the rest of the data. All coding was done using Atlas.ti software. I had seen this software used in other studies focusing on qualitative data analysis and, upon investigation, found its functionalities useful for my own purposes. Specifically, the ability to manage a large number of codes and large amounts of data, and the possibility to view all pieces of text associated with a particular code at the same time, which would be of great help in analysis. The codes I developed were each given a name, a number within the name, and a colour. Both the number and the colour were reflective of their relationship to other codes and broader related themes. The numbering of the codes can be seen in Table 2 and in the final codebook in Table 3 in the column labelled ‘SN’.

Human coders – as opposed to automatic computer coding programs – are prone to fatigue, subjectivity, and changing understandings of the codes over time, and it is therefore often advised to use a team of coders (Zhang & Wildemuth, 2009). Given the nature and scope of this project a team of coders was not feasible. To minimize the disadvantages of having only one coder, myself, the coding process took place over the course of about a week, with further reviews a couple weeks later, and regular consultations of the codebook. I also employed the “constant comparison” method from Glaser and Strauss (as cited in Bradley et al., 2007, p. 1762) of comparing newly coded text segments with other text segments that had previously been assigned the same code, in order to determine whether they reflect the same concept or instead require a new code.

3.5.1 Initial codebook

Table 2 Initial codebook

SN	Code	Description	When to use
1	Prior	Reviewer's experiences with the GP and their offices prior to the consultation(s)	Use for references to interaction with other staff at the GP's office, for example receptionists, the office environment itself, including the waiting room, or any factor directly related to the reviewer's experience prior to the consultation
1.1	Convenience	Reviewer experiencing convenience of factors or activities associated with the offices and consultation	Use for references to convenience of activities such as booking appointments and waiting times, office parking etc.
1.2	Inconvenience	Reviewer experiencing inconvenience of factors or activities associated with the offices and consultation	Use for references to inconvenience of activities such as booking appointments and waiting times, office parking etc.
2	Consultation	Reviewer's experiences with their face-to-face consultation(s) with the GP	Use for references to the reviewer's experiences during their consultation/s with their GP, including the reviewer's perception of their GP's interpersonal manner, communication skills, and clinical competence
2.1	Personality factors	Reviewer highlights certain positive or negative personality traits of their GP	Use for reviewer references to their GP's personality qualities, both without context, and to explain how such qualities affected their satisfaction with the consultation
2.2	Being heard	Reviewer feels that their GP actively listens to them	Use for references to the GP listening to the reviewer's worries/symptoms/issues, taking them seriously, and the reviewer feeling 'heard'
2.3	Participation	Reviewer feels they were or were not encouraged by their GP to participate	Use for reviewer's references to being involved or excluded from decision-making regarding treatment, or general feelings of being an active participant during the consultation
2.4	Technical competence	Reviewer's opinion on their GP's technical or clinical competence	Use for reviewer's judgments of their GP's clinical skills or abilities, mentions of instances in which the GP made a in/correct diagnosis or chose an in/effective treatment
3	Follow-up	Reviewer's experience with the GP and their offices following consultation(s)	Use for references to interaction and experiences with the GP, their office and their staff following the consultation. For example referrals, prescription refills, and reviewer's overall satisfaction
4	Established relationship	Reviewer feels they have established a relationship with their GP	Use for references to long-term or established acquaintance with the GP, either socially or as a patient, and phrases related to continuity of care
5	Comparison	Reviewer actively compares the GP to previous GPs they have visited	Use for any reference to the GP comparing favourably or unfavourably with other GPs, including references that imply the comparison rather than explicitly comparing two particular GPs

3.5.2 Results from trial coding

The trial coding of 20 reviews revealed that most of the initial codes were appropriate for the data, with the exception of 'Participation', which was not used at all and was therefore taken out of the codebook, to be put back in pending relevance. Additionally, a number of new codes were added to expand on Lopez et al.'s (2012) three-stage conceptualization of a doctor's visit, as more variation was needed for the data and the level of analysis that I saw was possible. To this end, a number of codes were added to the codebook during the initial trial coding.

It was also apparent that some of the initial codes, while reflective of strong themes in the 20 reviews used for trial coding, were perhaps too broad for the first stages of coding. For instance, the theme and code of 'Being heard' originally covered all statements relating to the reviewer feeling that their GP listens to them as a patient, hears their concerns, and takes them seriously. During the trial coding it became apparent that the GP listening and the patient being taken seriously were both mentioned frequently enough on their own as to deserve their own separate codes. 'Being heard' was also renamed as 'GP listens/is present/pays attention' to reflect the language of the reviews. Similarly, one of the first new codes added during the trial was 'feeling cared for', and by the end of the trial this had been separated into 'reviewer feels cared for' and 'GP cares for the reviewer'.

Such discoveries and decisions reflect my realization during the trial that it might make the most sense to start the coding process with a wider range of descriptive codes that could rise out of the data. Then, in later stages of coding and analysis, I could aim for the deeper, more analytical codes that reflect patterns and ideas behind the single or multiple descriptive codes.

New codes introduced during trial coding:

- 'Reviewer feels taken care of'
- 'GP cares for reviewer/patients'
- 'Professionalism'
- 'Referrals'
- 'Doctor's experience'
- 'Clinic staff'
- 'GP takes their time'
- 'Reviewer references other reviews'
- 'Reviewer moved/is moving from municipality'
- 'Sympathetic/empathetic/compassionate'
- 'GP understands reviewer'
- 'Trust/confidence in GP'
- 'Sick leave/medical certificate'
- 'Thoroughness'
- 'Specific example of past treatment'

4 Results

4.1 Final codebook

During the design of this thesis and even after having conducted the trial coding, I had based my coding on that by Lopez et al. (2012) and their aforementioned three-stage understanding of a doctor's visit (prior to the consultation, during the consultation, and following the consultation). While I found this framework useful in separating my initial codes, and it was possible to apply such a structure to the data during the trial coding, I ultimately found it more suitable for my objectives to use it as just that: a framework and organizational tool for the codes I developed. I began the coding process by using this framework more strictly, but as evident even in the results from the trial coding, it soon became clear that because my aim was not to simply catalogue the frequencies of codes, the three-stage structure was not of most importance.

Instead, as coding went on I expanded and adjusted my codebook to reflect the themes and topics that naturally emerged from the data. This process was informed by my previous literature search and understanding of relevant theories, but I was also focused on not simply imposing my own expectations onto the data. In other words, the focus was again on inductive rather than deductive reasoning and analysis. As mentioned earlier in the coding section, the focus was on looking beyond the who-what-when-where's within the reviews, to see the assumptions, values, and norms behind what the reviewers wrote in their reviews. The following questions from Charmaz (2003, pp. 94-95) were used to guide this process:

- What is going on?
- What are people doing?
- What is the person saying?
- What do these actions and statements take for granted?
- How to structure and context serve to support, maintain, impede or change these actions and statements?

The final codebook (Table 3) shows the complete list of codes applied to the sampled reviews. From 11 codes described in the initial codebook developed before the trial coding, a further 33 codes were added during the coding process. Many of the them are descriptive,

some are thematic, and as mentioned, a few serve mainly as organizational codes that helped me to structure more meaningful codes – as well as to allow me an overview of all text segments relating to a particular aspect, such as the discussion of aspects prior to the consultation. It may therefore be important to note that not all of the final codes were significant or prominent enough to be mentioned in the discussion section of this thesis.

After I had finished coding I reviewed each code and the segments of text associated with it to check for coding consistency. Some segments had to be re-coded, and the codes were then assessed for consistency again. When I had consistently coded all 120 reviews in the sample, I again examined my codes and their linked segments of text, this time looking for the broader themes that they fit into. As a consequence, in my discussion of the results I have combined some themes and drawn connections between others. I have also included some more descriptive summaries of the issues raised by reviewers and the manner in which they were raised, in the hopes of further illuminating the themes.

Table 3 Final codebook

SN	Code	Description	When to use
1.0	Prior	Reviewer's experiences with the GP and their offices prior to the consultation(s)	Use for references to interaction with other staff at the GP's office, for example receptionists, the office environment itself, including the waiting room, or any factor directly related to the patient's experience prior to the consultation
1.1	Convenience	Reviewer experiences convenience of factors or activities associated with the offices and consultation	Use for references to convenience of activities such as booking appointments and waiting times, office parking etc.
1.2	Inconvenience	Reviewer experiences inconvenience of factors or activities associated with the offices and consultation	Use for references to inconvenience of activities such as booking appointments and waiting times, office parking etc.
1.3	Clinic staff	Reviewer's experience in interacting with other staff at the clinic	Use for references to receptionists, secretaries, and any other staff at the GP's clinic apart from the GP
1.4	Availability	Reviewer's experience with trying to access the clinic or book a timely appointment	Use for references to how long patients must wait before an appointment with their GP is available, whether they can get an appointment on short notice, and to perceptions of the GP's general availability
1.5	Waiting times	Reviewer's comments on waiting times at the clinic	Use for references to time spent in the waiting room before a consultation with their GP, with or without an appointment
1.6	Phone service	Reviewer's experiences in contacting the clinic via telephone	Use for references to the degree of in/convenience in contacting the clinic by phone, being put through to receptionists or receiving recorded messages, waiting times on the phone etc.
2.0	Consultation	Reviewer's experiences with their face-to-face consultation(s) with the GP	Use for references to the reviewer's experiences during their consultation/s with their GP, including the reviewer's perception of their GP's interpersonal manner, communication skills, and clinical competence
2.1	Personality factors	Reviewer highlights certain positive or negative personality traits of their GP	Use for reviewer references to their GP's personality traits, both without context, and to explain how such qualities affected their satisfaction with the consultation
2.1.1	Sympathetic/empathetic/compassionate	Reviewer's experiences with their GP's sympathy, empathy, or compassion	Use for direct patient references to their judgement of their GP's sympathy, empathy or compassion, either in specific cases or as a general character trait
2.1.2	Understanding	Reviewer feels that their GP does or does not understand them	Use for references to the GP's ability and effort in understanding the patient's feelings or medical concerns, as well as whether or not the reviewer feels understood by their GP

2.1.3	Respect	Reviewer feels that their GP respects them and/or treats them with respect	Use for references to the reviewer feeling that their GP does or does not respect them, as a person and/or as a patient, and whether or not they feel treated with respect
2.1.4	Trust/confidence	Reviewer does or does not trust and have confidence in their GP	Use for reviewer's references to feeling as though their GP is trustworthy or not, expressions of confidence or a lack of confidence in their GP, either their technical abilities or in a general sense
2.2	Listens/present/pays attention	Reviewer feels that their GP does/does not listen, pay attention, or is/is not present	Use for references to the GP's listening skills, their ability to be fully present in the consultation and to pay attention to the patient and their concerns. Also for references to the reviewer feeling that they were or weren't listened or paid attention to
2.3	Supportive/reliable	Reviewer feels that their GP is/is not a source of support and/or can be relied upon	Use for references to whether or not the reviewer feels that the GP is supportive or reliable, and whether or not they feel that they are able to rely on their GP and use them as a source of support
2.4	Technical competence	Reviewer's opinion of their GP's technical or clinical competence	Use for reviewer's judgments of their GP's clinical skills or abilities, mentions of instances in which the GP made a in/correct diagnosis or chose an in/effective treatment
2.5	Communication	Reviewer's experiences with their GP's communication skills	Use for references to the GP's communication skills, for example their skill in listening to the patient, explaining treatments or choices, or body language and knowing when to talk
2.5.1	Answers questions	Reviewer is dis/satisfied with their GP's ability to answer questions	Use for references to the reviewer feeling that the GP did/did not answer their questions adequately, in an understandable manner, and address their concerns while answering
2.6	Good with children	Reviewer feels/does not feel that their GP works well with children	Use for reviewer's judgement, from personal experience or impression, of their GP's ability to treat children and to work well with them
2.7	Medication	Reviewer's experiences with their GP and medication	Use for references to the GP's attitudes towards medication, ease with getting prescriptions, etc.
2.8	Reviewer feels cared for	Reviewer feels/does not feel that their GP cares for and about them	Use for expressions of feeling personally cared for and about by their doctor, either in general or with specific examples
2.8.1	Doctor cares	Reviewer feels that their GP cares about them or their patients	Use for references to the GP caring about the reviewer personally and/or their patients in general
2.9	Takes their time	Reviewer feels that their GP does or does not take their time	Use for references to the GP taking their time, being rushed, seeming in a hurry, or other reflections on whether or not the reviewer feels that their GP uses adequate time for the consultation

2.9.1	Efficiency	Reviewer's perception of their GP's efficiency	Use for references to the GP's efficiency, both positive and negative. Overlap with being rushed, above.
3.0	Follow-up	Reviewer's experience with the GP and their offices following consultation(s)	Use for references to interaction and experiences with the GP, their office and their staff following the consultation. For example referrals, prescription refills, and payment
3.1	Referrals	Reviewer's experiences with receiving referrals from their GP to specialist services	Use for any references to receiving or needing referrals to specialist services, and to follow-up on referrals and dealings with specialists that are connected to their GP
3.2	Sick leave	Reviewer's experiences with being granted sick leave or provided with a medical certificate	Use for references to the reviewer's experiences with their GP's willingness or responsiveness in providing medical certificates, or the GP's assistance in the reviewer being granted sick leave
3.3	Outside the office	Reviewer mentions contact with GP outside the office or outside office hours	Use for references to doctor-patient contact outside of the doctor's offices and the consultation, for example personal phone calls to check on their health status
4.0	Established relationship	Reviewer feels they have established a relationship with their GP	Use for references to long-term or established acquaintance with the GP, either socially or as a patient, and phrases related to continuity of care
5.0	Comparison	Reviewer actively compares the GP to previous GPs they have visited	Use for any reference to the GP comparing favourably or unfavourably with other GPs, including references that imply the comparison rather than explicitly comparing two particular GPs
5.1	Doctor-shopping	Reviewer exhibits doctor-shopping behaviours in their review	Use for references to doctor-shopping behaviours such as reading reviews for other GPs, considering other GPs in their area, 'shopping around' for a new GP, or in other ways displaying general consumer behaviours relating to their GP or others
5.2	Would never switch	Reviewer declares they would never switch GP	Use for direct declarations of the reviewer's intentions to never willingly switch to another GP, and to cases where they were forced to switch through circumstance but had not done so willingly
6.0	Professionalism	Reviewer's experience of the GP's and clinic staff's professionalism	Use for direct references to un/professionalism on behalf of the GP and the clinic staff, as well as examples of behaviours which suggest un/professional behaviour
6.1	Thoroughness	Reviewer describes their GP as thorough or lacking in thoroughness	Use for direct references to the GP's thoroughness or lack of thereof, for example fully investigating the patient's symptoms and concerns. Also used for described behaviours that suggest thoroughness or a lack thereof

6.2	Experience	Reviewer's judgement of their GP's clinical experience	Use for mentions of how many years the GP has practiced, or general opinions on their level of clinical/professional experience
6.3	Enjoys job	Reviewer feels that their GP does or does not enjoy their work	Use for references to the GP enjoying their work, seeming engaged and interested in the tasks, or other intangible impressions noticed by the reviewer
6.4	Bored/indifferent	Reviewer feels that their GP is bored or indifferent	Use for references to specific behaviours from the GP which are judged to indicate boredom or indifference towards their work or the patient, or to general impressions that they are
7.0	Engagement with reader	Reviewer directly or indirectly engages with the reader in writing their review	Use for reviewer's references to the reader, either directly or indirectly, for example to give advice about the GP they are reviewing
7.1	Reference to other reviews	Reviewer directly or indirectly references other reviews of the same GP	Use for reviewer's references to previous reviews of the GP they are reviewing, for example to contradict an opinion or provide a counter-argument, or to agree/corroborate
8.0	Moved/moving	Reviewer will soon move or has moved from one municipality to another	Use for reviewer references to either having moved from one municipality to another in the past, or to soon making such a move. Particularly regarding switching GPs
9.0	Example of past care	Reviewer describes a specific example of their GP's past treatment	Use for reviewer's general reference to or detailed description of an instance of past treatment from their GP, for example treatment they received for a medical condition, a procedure or test performed by the GP
10.0	Mental health	Reviewer references their GP's handling of mental health issues	Use for references to the GP's competence in treating and handling mental health issues or psychological struggles, as well as to their attitude towards such issues and their attitude towards patients seeking help for them
11.0	Emoticon	Reviewer uses a text emoticon	Use for instances where a reviewer has included a text emoticon in their review, for example :-)
12.0	Direct thanking of GP	Reviewer appears to directly thank their GP in the review	Use for instances where the reviewer has used the opportunity to directly thank their GP in their review, either for a general matter or a specific instance of care. For example, "Thank you, [GP's name]"

4.2 Sample characteristics

Thematic saturation was reached at around 100 reviews, and thus the final number of sampled reviews was 120, as had been initially decided. The average age of the GPs reviewed was 48.7 years. Of the sampled reviews, 39 users (32.5%) reviewed female GPs, and 81 users (67.5%) reviewed male GPs. As intended, the sampled reviews showed some geographic spread, as seen in figure 1. The number of reviews sampled from outside of Oslo municipality was exactly 100, or 83.33% of the sample.

Figure 1 Geographic distribution of sampled reviews



4.3 Frequently occurring words

Excluding short, comparatively meaningless words such as conjunctions and pronouns, the most frequently occurring words in the sampled reviews are listed in Table 4. Only words used more than 20 times were included, as these were therefore likely to have been mostly unique uses and found in at least 10% of the sampled reviews. Words occurring less frequently than this tended to be more unusual words that were not representative of overarching themes. In some cases I have also included the Norwegian word, when the English translation can be any of several words.

The word frequency list was generated late in the coding process, and the interpretation that follows is informed by my general impressions upon reading the sampled reviews, and the thematic analysis in the discussion section. That is, the list and its interpretation is intended to illuminate general themes and to provide a general impression of the nature and content of the reviews.

The dominating frequency of ‘I’ was included to demonstrate the strong subjectivity of and reflexivity in the reviews, even more so given that the high frequency does not include shortened versions where ‘I’ has been left off but is implicit, for example “Have switched doctor”. When paired with the frequency of ‘doctor/the doctor’ and ‘GP’, the frequency of these words suggest the experiential rather than objective nature of the reviews, and their focus on the GP and the doctor-patient relationship rather than practical, organizational matters.

Another common feature of the reviews is captured in this frequency list: the frequency of the words ‘very’, ‘always’, ‘best’, and ‘never’ can be seen to illustrate the strength of opinion found in the reviews. Many reviewers felt either strongly positive or strongly negative towards their GP and the aspects of their GP or clinic that they mentioned. Variations of general statements such as “The best doctor I have had” and “The worst doctor I have had” (which also involve implicit comparison with former GPs) were common, although the former more so. This was expected, as previous studies show that the majority of online GP reviews are positive (Ellimoottil et al., 2012), and is also consistent with the idea that users are more likely to volunteer their review if they feel strongly about the subject.

Table 4 Frequently occurring words

Word	Frequency
I	221
doctor/the doctor	183
very	46
always	42
when	42
best	40
GP (<i>fastlege</i>)	39
<i>flink</i> , a Norwegian adjective denoting cleverness, proficiency, or skillfulness	35
good	35
<i>hyggelig</i> , a Norwegian adjective equivalent to nice or pleasant	28
seriously	26
<i>dyktig</i> , Norwegian adjective meaning skilled, skilful, or proficient	24
feel	23
satisfied or pleased	23
well	23
listens	22
the patient	22
never	21

Dividing the reviews into simple categories of ‘overall positive’ and ‘overall negative’ would entail a reductionism that would diminish the subtleties and variances in the content of “positive” reviews (B. Williams, 1994). However, it may be relevant to note that a clear majority of the reviews were generally positive in nature, and this is apparent in the frequency of words describing technical skill (*flink*, *dyktig*), and general positive descriptors (good, well, satisfied or pleased). The common focus on the patient-physician relationship, including interpersonal factors and personality traits/personal manner of the GP, is also suggested in the frequent appearance of words such as ‘*hyggelig*’, ‘seriously’, ‘feel’, and ‘listens’.

5 Discussion

5.1 Summary

Many of the issues and themes explored by the sampled reviews reflected those already identified in the literature and previous studies. The majority of reviewers focused on the GP as a person, both their interpersonal skills and their technical competence, and their experience with the GP during consultations. The most prevalent themes were those that emphasized softer, intangible factors such as those to do with communication, the GP's personality traits, and the doctor-patient relationship. This was expected and consistent with previous studies and the theory surrounding patient-focused care. Feeling as though they were taken seriously by their GP was perhaps the most important theme, along with feeling listened to, taken care of, understood, and treated with respect and empathy. In addition, it was also important for many reviewers that their GP spend adequate time on the consultation and on investigating and understanding the patient's concerns. This was also linked to the key theme of thoroughness, which had not been explicitly identified in the literature search, but did also appear in Folmo's (2014) recent study. Technical competence was another prominent theme, although it was mostly referenced by reviewers in a rather general way.

Service factors and aspects of the GP's clinic or medical centre were also mentioned frequently, although to a lesser extent. Again, the issues brought up in the sampled reviews were consistent with previous studies, the literature, and Folmo's (2014) study earlier this year. Common issues included: waiting times, availability, phone service, receptionists and other clinic staff, follow-up, and referrals and sick leave. The themes surrounding these factors were mainly about convenience, efficiency, and whether or not the reviewer felt that any inconveniences were 'worth it' to be able to visit that particular GP. The latter seemed to be largely determined by whether or not they felt that inconveniences were explained by the GP's positive traits/behaviours – such as the GP taking their time with each patient – and therefore whether they would rather endure longer waiting times in order to benefit from these same traits/behaviours.

5.2 Limitations

One limitation of the study is the translation method, as I am not a native speaker of Norwegian and despite consulting with one and using other language resources to ensure accurate translations, there may have been some nuances that were lost to me. However, it is also possible that given the nature of my content analysis, focusing as it did on themes, the essential meaning was still preserved enough for coding and analysis. Additionally, the vast majority of the reviews used everyday language that was already familiar to me. Nevertheless I must note the language difference as a possible limitation of the study. It would be interesting to see the results from a similar study done by a native Norwegian-speaker. Folmo's (2014) study, which was published during the writing of my thesis, has this benefit. The results are broadly consistent with my own, if not directly comparable due to her focus on coding frequencies and quantitative analysis. In a similar vein, although efforts were made to combat the possible negative effects of using only one coder rather than a team of coders, this still constitutes a potential limitation of the study.

Another limitation may be the sample size and the sampling method. As the goal was to attain thematic saturation, sample size was initially estimated by the number of reviews at which similar previous studies had reached thematic saturation, with consideration too for the scope of this project. This initial estimation proved accurate, and thematic saturation was reached. However, outside of achieving thematic saturation, a sample size significantly larger than my own might have yielded extra depth and illuminated broader themes within the data. For example, it may have led to further insight into the treatment of mental illness in primary care, as this was not a topic mentioned in all reviews and would require a large number of reviews to explore the issue in depth. Additionally, at the time of sampling Legelisten.no's browsing functionality only allowed for a maximum list size of 1,000 GP names. As I sorted GP names alphabetically, all sampled reviews were therefore drawn from GPs with a last name beginning A-F. If there is any significance to alphabetic placement, particularly regarding ethnic or cultural background – for example, there are no ethnic-Norwegian surnames beginning with 'q', 'x', 'y' or 'z' – it is possible that this had some influence.

Furthermore, sampling the most recent review may be a limitation – reviewers sometimes responded to or made mention of previous reviews, where they existed. It is possible that reviewers who had read previous reviews wrote shorter reviews as they did not feel the need to cover all the same issues, or that previous reviews may have guided their response in terms

of content or tone. On the other hand, reading other reviews could also bring up issues they may not have thought about, or could even have motivated them to write a review in the first place, to either agree or disagree. In any case, given that the number of reviews per selected GP varied quite widely (from 1 to over 20), picking every *n*th review would have resulted in a number of exceptions anyway.

We may not be able to generalize the results to the entire Norwegian population, particularly in light of Folmo (2014) finding that the reviewers on Legelisten.no are likely not representative of the Norwegian population – Legelisten reviews seem to be written by disproportionately more women, and individuals under 20 and over 60 years of age are underrepresented. However, Legelisten's users can choose not to provide their age and gender when posting their review, and Folmo (2014) found that only 64% of reviews included information on both the age and gender of the reviewer (p. 16). It is therefore difficult to know if Legelisten's demographics are representative of the Norwegian population. There may too be significant differences between those who choose to supply their age and gender and those who decide not to, both in terms of their motivations in writing their review, and in the content of the review itself. For instance, it is possible that users leaving a negative review are less likely to leave even vague clues as to their identity, especially if they are reviewing their current GP. There is also much that we do not yet know about the motivations for people writing reviews online.

5.3 Themes

5.3.1 Presence, listening, and communication skills

These themes are to some extent inextricably linked, both in concept and in experience, as is evident in the reviews. Reviewers who mentioned one, such as that their GP is a good listener, tended not to mention an opposing or contradictory trait. From the reviews and from the literature, I would suggest that these interpersonal traits and practices are something of a 'package deal', and also include themes of respect and empathy.

The most common references to a GP's interpersonal communication skills was reviewers' simple assertion that they were good at listening. This was often coupled with being taken seriously and being understood – sentences such as "Listens and understands" and "He listens

and takes you seriously” appeared frequently. As mentioned, these were also often explicitly paired with feelings of being respected, and that their GP was empathetic and compassionate. Similarly, another common statement within these themes was that the reviewer’s GP was “easy to talk to”. While this is quite a general statement, it contains within it notions of trust, safety, and comfort, along with basic interpersonal skills. Although ‘presence’ was not often mentioned explicitly in the reviews, it was an overarching theme behind many references to communication during consultations. That is, the reviewer’s feeling that their GP was actively engaged and paying attention to them during the consultation.

Some reviewers were more specific about the aspects of their GP’s communication style that they most appreciated, and the most common of these was a straight-forward manner and clarity in expression. For example, “She is a super doctor for those who like things to be said bluntly”, and, “She is direct and straight-forward and speaks directly to you in a way that is easy to understand”. The sampled reviews also suggest the importance of striking a balance between active listening and responding. For example, “Just sits and listens. Impossible to get clear answers to questions”, is a negative enough statement on its own, but doubly so when you consider the high number of reviewers who mentioned how important it was for them to get answers and solutions from their GP.

One reviewer’s discussion of her GP’s communication skills offers insight into the balance of communication and power during a consultation, as well as to how patients experience and understand nuances in communication:

... this is a doctor who gladly talks at the patient. I have several friends who have the same doctor and they report the same experience. This is probably not ill-meant from his side, but more a matter of some inability to follow a rhythm in a dialogue. Now the patient talks, now the patient is finished talking – now I can talk...

Instead, he interrupts in the middle of the patient’s sentence, either by speaking or with obvious body language (head-shaking etc.) that makes it clear that what you say, he very much disagrees with...

As noted earlier, the sampled reviews did not address issues of participation in the way in which it was discussed in the literature and in previous studies. Previous studies characterized patient participation as active participation and input into treatment options, decision-making and the like, which did not appear in the sampled reviews of this study. However, it may be

possible to view participation in a subtler way which encompasses basic aspects of a mutual dialogue between patient and GP, as described by the reviewer above, in which the patient is an active partner in the consultation. There was an element of this expressed in a number of reviews, although it was not prominent and from my impression was tied more to factors such as respect and being taken seriously, than to a desire to participate. As many studies on patient participation come from the US, I do wonder if the emphasis comes from cultural and system factors that are not as influential in Norway, where universal healthcare ensures access and society as a whole is less hierarchical. It is also possible that the sample size for this study was not large enough to capture the importance of participation to Norwegian reviewers.

5.3.2 Thoroughness and taking their time

Another major theme was whether or not reviewers felt that their GP took their time during the consultation, and whether they felt that their GP had time for them in a general sense. The former can be tied to thoroughness, which was also a prominent theme and frequently mentioned explicitly in the sampled reviews. And the latter can be tied to availability, an aspect of the clinic and the system surrounding the consultation, which I have covered in a separate section.

Thoroughness was frequently mentioned as a positive, in that their GP did not rush through the consultation, but rather used sufficient time to investigate the patient's symptoms and concerns. In this respect I have also linked thoroughness to professionalism in another section: "He is precise, examines carefully, if he doubts, he sends us for further examination at once". Both thoroughness and taking their time can also be connected to the importance of respect and interpersonal skills such as the ability to actively listen to the patient: "[GP's name] always tries to thoroughly understand the reason you sought out a doctor"; "[GP's name] is also very polite, and ends every appointment with, 'Is there anything else?'" In addition to quotes such as the above, a number of reviewers simply described their GP as "thorough".

In contrast to those praising their GP for taking their time, reviewers sometimes referred to efficiency during the consultation in a negative manner. Efficiency was universally valued in all other aspects outside of the consultation itself – quick referrals, follow-up, payment at reception, and fast connections to reception over the phone. A certain amount of efficiency was valued during consultations, but too much of it – or an approach suggesting it was the

main priority – seemed to be interpreted by reviewers as either hasty and lacking in thoroughness, or impersonal, or both. For example, “[The doctor] is too busy, so preoccupied with efficiency, that there is a lot of back-and-forth, little listening to the patient and my needs/problems”, and, “the doctor will preferably be finished with you as fast as it can be done”. Similarly, a small number of reviewers mentioned this in respect to their GP’s attitude toward writing prescriptions, for example: “Happy pills for you, and then you can go. So it felt after an appointment with this doctor”; “Is quick to print prescriptions, something I think is both positive and negative”.

Overall, the positive emphasis was on GPs taking the time they needed in order to thoroughly listen, understand, and investigate the reviewers’ symptoms and concerns. The majority of reviewers covered this issue in some way in their review, many of them simply noting positives such as, “He takes his time with you, and you feel prioritized”.

5.3.3 Genuineness and being taken seriously

One of the most prominent themes that emerged from the reviews was that of patients feeling that their GP did or did not take them seriously. Not only was this mentioned frequently, but it was often presented by the reviewers/patients as being fundamental to their satisfaction or dissatisfaction with their GP, appearing in the headlines of reviews and garnering mention in reviews that were only 2 or 3 sentences long. When a user reported that their GP did not take them seriously, the impact was naturally quite serious, affecting not only their satisfaction and their comfort level, but also their reported outcomes: “My previous doctor practically chided me if I asked to have an appointment, because it was never serious enough. Ended with many emergency visits.”

This feeling of being taken seriously by their GP was often tied to other aspects such as feeling as though their GP listened to their concerns, paid them full attention, and dedicated enough time to the consultation and the investigation of the patient’s troubles. It was my impression that behind such references lay broader expectations from many reviewers that their GP should be genuinely engaged with them on both a professional and a personal level throughout their interactions. Statements such as, “She seems genuinely interested in you as a person and your situation”, and “It is so obvious that this is a man who enjoys his job and takes his patients seriously”, were common. They can be contrasted with complaints from

some that their GP seems bored or indifferent: “He seems more and more indifferent to the patient” and, “Seems like he has been in the field too long and has become bored”.

Being taken seriously by their GP was a fundamental need expressed either explicitly or implicitly in almost all of the sampled reviews. The discussion surrounding it and the ideas connected to it, including markers that reviewers used to determine that their GP takes them seriously, suggest that this essential aspect may be one that cannot easily be faked. However where reviewers elaborated on the markers of being taken seriously, it often appeared that the GPs interpersonal and communication skills had contributed to giving the reviewer this impression – these are skills which can actively be improved upon, and which obviously benefit all other aspects of the consultation too.

I would also suggest that many of the aspects described above come under the umbrella of *medmenneskelighet*, a Norwegian word which is difficult to translate to English, but essentially expresses the idea of compassion, empathy, and fellowship with others. A number of reviewers referenced this idea in ways that are difficult to translate, but roughly equate to saying that their GP “met [them] as a fellow human being” and was in a general sense a good person. This may be the ultimate example of a softer aspect of the doctor-patient relationship that is difficult to measure objectively, and which some patients may only be able to explain in vague terms.

5.3.4 Emotional support and being taken care of

Although not expressed by all reviewers, a great many did express a feeling of being cared for and taken of by their GP. During the coding process I separated instances of ‘Reviewer feels cared for’ and ‘Doctor cares’, because of the distinction between a personal feeling of security, safety, and care experienced by the patient, and the reviewer’s assessment that their GP cares for and about them. In terms of frequency, there was an almost even split between expressions such as “I feel very well looked after”, and statements such as, “She cares about her patients”. While some instances may differ only semantically, I would argue that overall, the simple difference in word choice and perspective reflects two different aspects of the ‘care’ in primary care. ‘Reviewer feels cared for’ could describe an active sense of care in almost a paternal/maternal sense, or at least from a position of the GP’s authority over and for their patients. In this way, it could be somewhat connected to the traditional model of patient-doctor relationships of the past, with the patient as a passive recipient of the doctor’s care

(Lloyd et al., 1991). On the other side, ‘Doctor cares’ could reflect a general feeling within the theme of genuineness discussed above, where the reviewer perceives that their GP cares for their patient in a personal way that, while professional, goes beyond simple clinical treatment.

Nevertheless, there was an overall theme of many reviewers appreciating the feeling of being cared for and taken care of by their GP. This combined with emotional support and reliability paints a picture of some patients deriving far more than straight-forward medical help from their GP: “Was an amazingly good support when life didn’t feel good to live”. However, this may simply be more common among patients who are motivated to write an unsolicited review online, whether due to a very high level of satisfaction with their GP, or due to other factors that require further investigation.

5.3.5 Mental illness

One of the most unexpected themes that emerged was the GPs’ understanding of and competence in treating the patients’ mental or psychological troubles. Although mentioned by less than 10% of the reviews, those reviews that mentioned it focused their attention on the matter, and several other reviewers made mention of their GPs helping them in the treatment of addiction issues, or through generally difficult times in their lives.

Overall, among reviewers who brought up their mental or psychological struggles, about half were dissatisfied with how their GPs handled their troubles at the time. Those who were dissatisfied often referenced a persistent stigma towards mental illness and the difficulty of talking about it, particularly with a new doctor. One reviewer says of their doctor: “Made me feel labelled mentally ill despite the fact that I have not been troubled mentally for a long long time. Not a good feeling to walk out of the doctor’s office with.” Other reviews on the topic reflected this need to feel taken seriously by their GP while dealing with mental troubles, rather than marked by the same stigma that can often be felt throughout the rest of society.

Another reviewer summarized the situation thusly:

[Name] is a skilled general practice doctor, but falls somewhat behind in a deeper understanding of mental illness. Something that I believe is a problem with most GPs as I see it. That the topic is already taboo and difficult to talk about, does not make it easier to choose a doctor when it really matters.

In obvious contrast, reviewers who reported positive experiences with their GP in similar circumstances praised the openness of their GP, and their willingness to spend extra time simply talking: “The first time I came to him and told him what was wrong, he received me with open arms and spent a long time talking to me”; “...I received several follow-up sessions afterwards, really only to chat and find out which emotions could lie behind it”.

None of the reviews focused on mental troubles, positive or negative, mentioned the patients receiving referrals to mental health specialists, although it is certainly possible that they did. In Norway, GPs have a larger responsibility in dealing with the mental health of their patients than in some other countries, being responsible for areas including the evaluation and treatment of patients presenting with mental health troubles (Ringard, Sagan, Saunes, & Lindahl, 2013, p. 115). GPs also act as the ‘gatekeeper’ to mental health specialists. It may simply be that patients who are quick to receive such a referral – and financially able to follow up with it – are less likely to write such a review online.

It could be, however, that there exists a disconnect between primary and secondary mental healthcare, and that improved communication and coordination between primary care physicians and specialist mental health services would be more effective in improving the quality of mental health treatment in primary care. One study on Norwegian GPs and mental health professionals found that both groups agreed on the need for increased collaboration, consultation, and mutual knowledge between GPs and mental health professionals (Fredheim, Danbolt, Haavet, Kjongsberg, & Lien, 2011). Another qualitative study asked Norwegian GPs what could be done to improve the treatment of mental disorders in primary care and reported that 40% of GPs suggested improvements to GPs’ skills and knowledge in diagnosing and treating mental disorders, along with 40% of GPs who also suggested that patients with mental disorders could have more time in GP contexts (Mykletun, Knudsen, Tangen, & Overland, 2010). These suggestions appear to be in line with the issues expressed in the sampled reviews, and are consistent with this year’s OECD report, which suggests additional training and support for GPs to improve their treatment of mild-to-moderate mental illness (OECD, 2014).

Although it is well outside the realm and scope of this study to draw any conclusions regarding mental health competencies in primary care in Norway, the sampled reviews suggested that efficacy in this area may at least hinge in part on the attitude and openness of the GP. The reviews show that feelings of being accepted and taken seriously, rather than

judged, were important and a key factor in reviewers finding a GP who was the right ‘fit’ for them.

5.3.6 Established relationship

There were more than 30 mentions – most of them in unique reviews – of multi-year and even multi-decade client relationships between the reviewing patient and their GP. With a sample of this size, this is a significant number. In many cases, mention was made not only of the duration of the individual patient-doctor relationship, but also of the GP’s standing as “the family doctor” – GP not only to the reviewing patient but also to the patient’s immediate family and/or social circle. For example: “[GP’s name] has been the whole family’s doctor for many years”; “My GP throughout 22 years, and my mother’s, my best friend’s and her children’s doctor”.

Unsurprisingly, many of the reviewers referencing established, long-term relationships with their GPs also include examples of previous life-stages and treatments through which they have been treated by the same GP. Reviewers’ use of concrete examples is discussed in a later section, but common cases here include both general references and specific conditions: “He has followed me through thick and thin for the past 8 years”; “Have gone to him for over 10 years with everything from foot warts to depression”. Such examples speak not only to implications for the GP’s versatility and technical competence, but also to their reliability and ability to take care of their patients – other themes of importance to the sampled reviewers, regardless of the duration of their patient-doctor relationship. Within this context, such continuity of care and satisfaction over time seems to represent the ideal model of primary care for patients holding these values; the goal towards which dissatisfied reviewers strive for through doctor-shopping.

Additionally, the prevalence of long-term doctor-patient relationships among the sampled reviews may have implications for the motivations of people posting to PRWs, as well as the nature and content of their reviews. It is possible it is a factor in why the majority of online doctor reviews are positive, and could be linked to “halo” effect observed by Mead et al. (2002), where familiarity and level of acquaintance with the doctor is seen to positively impact patient satisfaction. This is also consistent with Detz et al.’s (2013) finding that of online GP reviewers who self-identified as having a long-term (one year or more) relationship with their physician, 86% wrote positive reviews, compared to 55% of other patients.

The continuity discussed above can be contrasted with a number of mentions of substitute doctors filling in for the reviewer's regular GP. In fact, one reviewer titled their review "The Ghost Doctor", after having not seen his 'regular' GP in the entire 3 years that he had been on his patient list. Other references suggest that if there are rational organizational reasons behind such substitutions, the reviewer may not always be aware of them: "4 or 5 times we have booked an appointment with [GP's name], we have gotten a different doctor!" However, it is difficult to say given the subjective nature of the reviews. Given the list system in Norway, which encourages and supports long-term doctor-patient relationships in primary care, it is understandable that patients would object to their 'regular' GP being less than regular. This problem has obvious ties to issues of availability, covered in another section, and seems to hinder the development of the kind of long-term doctor-patient relationships described above.

5.3.7 Geography and loyalty

A noticeable number of reviewers wrote their review in the context of either soon moving away from the municipality where their GP is located, or having moved away in the past. This unexpected theme may be the result of my sample being taken from all of Norway, which would explain why it was not as prominent in Folmo's (2014) study. Moving within Oslo municipality still means that most other areas in the municipality are reasonably accessible, whereas for patients outside of the capital, geographic distance and public transport accessibility may play a bigger part in choosing and keeping a GP. Additionally, many people from smaller towns move to larger cities for study or work at various points in their lives, which may represent what are effectively GP-switching-points.

Of the reviewers who mentioned geographic distance or residential changes in their reviews, it was presented either as the only reason that they had changed from their GP, the only reason that they would soon be forced to change GPs, or as an obstacle which they had chosen to overcome rather than face changing their GP. For example, one reviewer notes that they "would rather drive a little farther than switch doctor", while another says, "I have had [GP's name] as GP for many years. I moved from Klæbu 5 years ago, but she is still my GP". Still others report staying with their GP through the GP's clinic changes: "myself, my husband, my son and my father are therefore following him as he is now moving to another practice". Such

behaviours and attitudes represent a key holdover from traditional doctor-patient relationships based on loyalty, longevity, and an established relationship between doctor and patient.

While researching this thesis I wondered if this traditional doctor-patient relationship would be in contrast and friction with the demands of healthcare consumerism and doctor-shopping behaviours that have emerged in recent decades. Now at the other end of the thesis, it appears that the two may instead be consistent and complementary with one another. Unsurprisingly, reviewers who mentioned having a long-term, established relationship with their GP almost always expressed both overall and specific satisfaction with them. Of the minority who noted how long they had been with their GP and also noted dissatisfaction with them, the reviews overall often included both pros and cons of the GP and their clinic, and often expressed the desire to switch.

5.3.8 Technical competence

Although it is unclear whether patients are able to accurately assess their doctor's technical competence, studies show it is one of the most important factors for patients, rivalling and sometimes surpassing the importance of softer interpersonal factors (Fung et al., 2005). The aforementioned frequency of *flink*, a Norwegian word describing cleverness, skillfulness, and proficiency, is one example of the prominence of this theme in the sampled reviews.

References to technical competence were most often quite general – for example “She is a skilled doctor”, “solid technical background”, “very proficient in his profession” – and in fact it may have been the most mentioned and yet the least elaborated theme. A number of reviewers did specify particular skills, such as “very good with ‘hands-on’ care (wounds, small procedures etc.)”, and, “she is good with diagnosing, and the taking of pap smears”. It was fairly common for reviewers to note that their GP had a strong track record of correct diagnosis, suggesting that some may use this as a measure of technical proficiency.

Related to skill, some reviewers commented on their GP's extensive knowledge, or “good general knowledge”. There was not enough data, nor enough detail within existing data, to understand whether reviewers felt there was a distinction between technical competence and knowledge. However there was the suggestion, related to themes of genuine engagement and thoroughness, that some reviewers felt it was important for their GP to continue to actively acquire new knowledge relevant to their profession: “does not seem to be the sharpest in the

discipline. Doesn't seem to acquire new knowledge and offers sick leave rather than finding the problem."

Overall, while the dominance of the theme suggests its importance to the reviewers, the general nature also may suggest that reviewers are unable to say exactly why they believe their GP to be technically skilled. As an extension of this, it may be that reviewers rely on positive health outcomes and other unknown indicators, relevant or not, to signal a doctor's technical skill. Indeed, Ware and Williams (as cited in Fung et al., 2005) found that patients may believe they are receiving a high quality of technical care if their doctor has strong interpersonal skills.

5.3.9 Professionalism, courtesy, and friendliness

Where other staff working at the clinic were mentioned – almost always receptionists and secretaries – it was mostly in a positive light, and the focus was on interpersonal skills and customer service. Friendliness, courtesy, and professionalism was valued in both clinic staff and GPs, which is in line not only with the existing literature and previous studies, but also with basic social norms, particularly in a human industry like healthcare. General pleasantness and a smiling demeanour were praised in both clinic staff and the GP, although more frequently found in mentions of the receptionists and secretaries. This could simply be due to the vast difference in interactions the patient has with the two groups. Given these different interactions, it is also unsurprising that reviewers who mentioned clinic staff had a tendency to focus on aspects of customer service.

Where courtesy and customer service was perceived to be lacking, the impact could be significant, as one patient illustrates: "Poor service from office staff. Lump in my stomach at the thought of having to contact them." While this may be an extreme case, other occasional references to "bored", "unpleasant", or "inhospitable" clinic staff, as opposed to "smiling", "nice", or "polite", suggest that the reviewers' desired qualities in clinic staff may be rather simple when compared to their demands in a GP.

There were also many general comments regarding how "nice", "polite", "friendly" and "warm" some GPs are, and as mentioned in the above sections, personality factors and interpersonal skills were important in the majority of reviews. Negative traits were mentioned less often, given that most reviews were positive, but when mentioned they most often

referred to arrogance or coldness. Professionalism was sometimes mentioned explicitly, but was more often described through references to actions that demonstrated reliability and timeliness. For example: general follow-up with patients; ordering tests and giving feedback on them in a timely manner; sending referrals and following up with specialists; issuing medical certificates for sick leave; preparation for the consultation; and in some cases, returning phone calls outside opening hours. As discussed in the section on thoroughness, in many cases I also found behaviour and actions demonstrating thoroughness to imply a measure of professionalism.

There did not appear to be much tension between the demands of professionalism and the preference for softer personality traits. Given that courtesy is a part of professionalism and professionalism certainly does not preclude friendliness, this is perhaps not surprising.

5.3.10 Access and availability

When referencing the clinic in which their GP practiced – and other follow-up and system issues – reviewers focused on themes of access and availability. My initial codebook divided such references into ‘Convenience’ and ‘Inconvenience’. While this dichotomy certainly describes patients’ experience of such system factors in a broad way, throughout the course of coding and analysis it became clear that for the sampled reviews, the Convenience-Inconvenience divide was better understood as desires for access and availability. More particularly, issues that were brought up by reviewers included: phone service (how easy it was to access the clinic by telephone), availability (how quickly they could get an appointment with their GP), and waiting times at the clinic before their consultation.

Negative aspects of the clinic where the GP practiced were noted in both overall positive and overall negative reviews. Within positive reviews, negative aspects such as a long waiting time were often still seen to be ‘worth it’, and the natural consequence of a doctor who takes their time with patients: “Often 20-60 minutes waiting at the doctor’s office, but it has actually been worth it to go to a doctor who listens and takes their time when you finally get in”; “You must tolerate some waiting with him, but when you finally go in you understand why”. In such cases, already satisfied patients understood long waiting times to be the natural accompanying disadvantage to an overwhelming advantage, suggesting that some patients can accept such inconveniences if they feel that they are also reaping the connected benefits in some way. However, not all reviewers who mentioned long waiting times saw or made

mention of this connection, and they were usually those who were generally dissatisfied with their doctor, suggesting that their satisfaction with other factors and impressions of their GP could affect their perspective on aspects of the clinic and qualities of their GP that could be both positive or negative.

The exception seemed to be waiting times over the phone, which was a common complaint, as there was no similar level of understanding regarding delays or inconveniences with respect to telephone service. Comments such as “practically impossible to reach by telephone” were common, and were often present within otherwise positive reviews. For instance, the following quote came from a reviewer praising their GP for being “everything a doctor should be and even more”: “the only BIG negative is that it’s almost impossible to get through on the phone, can quickly wait more than 20 minutes to get an answer, a little boring”. In fact, the only positive comment regarding phone service found among the sampled reviews was one comparing one clinic with others in the area: “This is the only medical centre in Eidsvoll where it is possible to get through on the phone”. Phone service was mentioned in around 10% of reviews, and in all but one case were negative and constituted a source of frustration and inconvenience for the patients. A study by Godager and Iversen (2010) found that of the surveyed patients, the proportion who reported having to wait between ten minutes and one hour before being put through on the phone at their GP’s office rose from 16% in 2005 to 19% in 2008 (p. 17). They also note that in 2008 a minority of patients marked the question as non-applicable, given that the booking of appointments at the clinic was done over the internet (Godager & Iversen, 2010), which could save many patients and receptionists a great deal of time and frustration.

Reviewers expressed similar frustration over their GPs’ availability, in terms of how long they had to wait before they could get an appointment, although here it was almost an even split between positive and negatives references. Reviewers seemed to focus most on their GP’s availability when they needed an appointment on short notice for an acute problem. This may simply be because acute health problems are often a stressful, emotional experience when the availability of a patient’s GP is of utmost importance, and could become tied into issues of trust and the patient feeling as though they can rely on their GP. Positive references regarding availability reflected a sense of constancy and reliability, such as the following: “Takes me without appointment if it is acute”, “I always get an appointment when needed”, and “Always gives an appointment on the day”. On the negative side, the lack of availability was extreme

in some cases: “Almost impossible to get an appointment (was actually referred to use the emergency room, when they didn’t have an available appointment for an acute matter until about 2 weeks)”.

Reviewers desires for access and availability is consistent with Folmo’s (2014) finding that reviewer satisfaction was higher with GPs who had shorter patient lists (p. 58). This was reflected in reviewers who noted that their GP had “a lot to do” and many patients, which lowered their availability and made it difficult to get an appointment, particularly on short notice.

5.3.11 Doctor-shopping, recommendations, and comparisons

Although it was only occasionally mentioned explicitly, the sampled reviews did exhibit signs of doctor-shopping behaviour, along with thinking and reasoning patterns in line with doctor-shopping. (Here, of course, I use the understanding of doctor-shopping set out in the theory and coding section of this thesis.) For example, some patients made explicit and implicit reference to their priorities in choosing a GP: “It was my intention to have a GP with experience”; “For my part, I am only looking for solutions and short doctor’s visits, and then he suits perfectly”. This tendency demonstrates differing needs and priorities across different patients, and I would posit that the process of both writing and reading a review engages patients in an active reflection on what they most want and need from a GP.

Recommendations of GPs was also common, and some reviewers combined a statement of their priorities in a GP with a recommendation to those reading: “For those who are looking for a doctor who chats a lot and is very social, then [name] is not the doctor for you”; “A good doctor if you don’t go there often” etc. In fact, such recommendations seemed to be simply the overt version of the implicit advice contained within the former expressions of the reviewer’s priorities. That is, statements of the reviewer’s priorities in choosing a GP serve to not only give some framework for the opinions in their review, but also to advise the readers based on similarities and differences they can see between themselves and the writer. Far more general, straight-forward statements of recommendation were also given, and more frequently, for example, “recommend everyone in the Averøy area to choose [GP’s name]”.

In making such direct and indirect statements of priorities, a great many reviewers compared their GP to previous GPs they have had, or in some cases, to other potential GPs in the area.

In a sense, this was done in the frequent use of general superlative statements and headlines such as “Simply said, the world’s best doctor”, or, “The worst doctor I have encountered”. As shown in the section on frequently occurring words, a great many referred to their GP as “the best”, and it is also very possible that many of these claims were in fact not superlative but rather a simple and truthful comparison with previous GPs. Particularly because a number of reviewers provided more detail: “I have had several doctors throughout the years and [name] is the best I have had”; “I.. experienced a security with her that I have not experienced with other doctors”. Comparisons with previous GPs were more often general and holistic than specific, although the latter did appear.

As mentioned, reviewers sometimes referenced other GPs in the area. Although this was not particularly common – perhaps because the majority of reviews were from satisfied patients who had no current desire to change GPs – when it did occur it revealed a very clear tendency towards doctor-shopping that was reflected in subtler ways in many other reviews. For instance, one reviewer wrote, “Why have I not switched before? There are only 2-3 doctors here with spare capacity. And from what I hear, those aren’t any better... So you might as well just bite the bullet while one checks the GP-capacity weekly!” However it is possible that patients with a higher level of health care needs are more likely to actively engage in the search for the right GP for them (i.e. doctor-shopping), including participation in reading and writing reviews on PRWs and checking GP-capacity. For instance, a recent study of German patients found that those with chronic diseases were more likely to use PRWs than those without (Terlutter, Bidmon, & Röttl, 2014).

Overall, there was a high awareness of choice in the sampled reviews. Explicitly and implicitly, the reviewing patients were consciously aware of the fact that they could change GP at any time – many expressed no desire to change, or had been forced through circumstance to switch, while others were in the process of actively searching for another doctor or reporting on the outcome of a past choice. Some framed their decision in the context of a single negative experience that decided their decision: “Was sent back to work with pneumonia. Changed GP immediately.”; “After a particularly uncomfortable pelvic exam, it was the last straw that made me switch.” In general, most demonstrations of doctor-shopping in the sampled reviews seemed to be focused on physician-related factors, primarily clinician characteristics, although there were some cases where office factors (e.g. availability) and

reviewers' health needs (e.g. chronic illness) were the driving causes (Sansone & Sansone, 2012).

5.3.12 Timing and purpose of writing the review

Prior to coding, I had unconsciously expected the majority of users to be reviewing their current GP, and was thus surprised to find that a fair number of users chose to review GPs they had been to in the past. While my surprise was perhaps unwarranted, given the nature of other consumer reviews online, users who chose to review past GPs led to my reflection on the timing and purpose of writing reviews.

A number of users appeared to use the review as a way to thank their GP, sometimes directly: "Thanks for all the help"; "[GP's name] YOU ARE BEST"; "Thank you, you deserve flowers and more praise". Indirectly, a number of (positive) reviews gave the impression of having been written as an act of kindness and appreciation towards their GP, as well as to past GPs. The occasional inclusion of smiling text emoticons contributed to this impression.

5.3.13 Engagement with readers and other reviews

An aspect not covered in my initial literature review (perhaps due to the parameters of my review) was the ways in which the users/reviewers/patients engaged with their readers and with other reviewers, both directly and indirectly, in their reviews. For instance, a number of users made reference to other reviews of the same GP in their own review: "I do not understand at all the criticism below"; "as mentioned in other reviews"; "as has been said here". One user even simply said, "I really agree with an earlier description I read", and then proceeded to quote the earlier review in full.

This interactive quality is a large point of difference between traditional methods of gathering feedback from patients, such as surveys, which are usually one-directional and private. But users may also be influenced by the content and/or tone of other users' reviews of the same GP, or even spurred to write the review in order to agree or disagree with another review. This quality can be seen as both an advantage and a disadvantage of such PRWs. On the one hand, readers and researchers are privy to differing opinions on the same factors, with the voices actively engaged with one another. This is of benefit to readers, especially prospective patients, as it provides balance of opinion (particularly in the early stages of a PRW when

reviews are lacking) and may also provide a reminder of the subjectivity of the reviews. For GPs, too, it gives another perspective on what patients want, and can indeed offer something of a reputational defence against an angry patient (in some cases). And for researchers, it grants us a look at how different patients respond to the same quality, behaviour, or process.

Other features of the text, such as the use of text emoticons, also reflect this new arena of patient feedback. Emoticons were used in 10% of the sampled reviews, all of them positive – smiling faces – and generally following either a direct thanking of the doctor or a general positive statement of satisfaction or recommendation.

5.3.14 Concrete examples

Another indirect way in which reviewing patients reflexively engaged with their readers was through the use of concrete examples of specific past experiences with the GP, usually consultations or medical conditions they treated over time. These personal, specific examples served a number of purposes: they gave a certain amount of credibility to and justification of the reviewer's opinion; they provided context for both the reader and reviewer; they were more illustrative and persuasive than general statements about the doctor; and for a dissatisfied patient, the sharing of the experience perhaps provided an emotional outlet of sorts.

The majority of concrete examples described negative experiences, usually regarding service/interpersonal matters and instances where the patient perceived a lack of thoroughness or technical competence. Generally, examples of negative experiences supporting a negative review tended to be more detailed than those from satisfied patients. For example, contrast “He has also followed me through an entire pregnancy”, with another patient's detailed account of a negative experience:

Also had an appointment there and had informed them in advance that I had another appointment a little later. This was in the afternoon, the office and the reception were empty (the last of them left after welcoming me), with the exception of the three doctors who had a meeting in one of the offices. After waiting for over an hour (and having asked one of the doctors who were out for a walk if they would be finished soon), I had to just leave in order to catch the other appointment. I had to get an emergency appointment the next day, and they were so rude as to say ‘Yes, if you had

only gone to your appointment yesterday, then...’

While such negative examples may arguably be unfortunate one-off experiences, their primacy within the dissatisfied patient’s review suggests that they may be viewed as emblematic of the reasons behind the patient’s general dissatisfaction with their GP. As positive examples were often broader in nature, it seemed that this reflected the patient’s general satisfaction with their GP. Also, perhaps, a lack of overwhelming negative experiences over a significant period of time, as many of the positive examples indicated or implied the existence of a long-term patient-doctor relationship. This could be explained by Nelson and Larson’s (1993) theory that patient’s express satisfaction when there have been no ‘bad surprises’, and that the occurrence of ‘bad surprises’ breaks patient expectations and lead to expressions of dissatisfaction.

5.4 Comparisons

This thesis was originally conceived and designed in March of 2013 for a research design course at the University of Oslo. In September of 2014 Legelisten.no’s blog posted results from a similar study, a thesis completed at the NHH in Bergen in Spring 2014. My thesis is entirely independent from this other study, and I was not aware of it at all while preparing for my own thesis. As a key point of difference, the Folmo (2014) thesis includes a qualitative content analysis of Legelisten.no reviews sampled from 4 different areas of Oslo municipality, while my sample had no geographic restrictions due to my differing research aims. Folmo (2014) also chose to sample up to three reviews from the same GP, whereas I chose to sample only one review per GP in the hopes of gathering a larger variety of physician styles. It is unclear what effect this difference may have had on the results of each study.

The thesis by Folmo (2014) used a sample of over 346 reviews from Oslo county for their qualitative content analysis. While it is not explicitly stated in the report, this number appears to be based on the sampling method, *also* by Lopez et al. (2012) – 10 reviews from the beginning, middle, and end of the sampled geographic area – rather than on a judgment of the number of reviews needed for the analysis. I had considered using the same method in March 2013, but ultimately decided against it because reaching thematic saturation was my main objective in sampling. Indeed, within the same study, it is noted that thematic saturation was

reached at around 60 reviews (Folmo, 2014). For my thesis the quantitative frequency of thematic codes was less important than finding patterns and nuances within the themes themselves.

Overall, my results are consistent with the results of the qualitative content analysis section of Folmo's (2014) study. Despite the fact that Folmo (2014) and I used different methods to categorize codes, interpersonal aspects relating to the GP and the consultation were the biggest focus of the sampled reviews in both studies, with aspects relating to the clinic appearing less frequently. Key themes from my study which were also reflected in Folmo's (2014) include: being taken seriously by their GP; the GP's listening skills; technical competence; taking their time; communication skills; empathy; and accessibility. Points of difference included the focus on referrals (not quite as prominent in my own sample), the specific mention of eye contact (incidence was lower in my study), and the positive references to efficiency (my own sample often saw efficiency negatively). In my thematic analysis I also identified themes such as loyalty to the GP and the GP's competence in handling mental illness, which were not mentioned in the Folmo (2014) study.

However these differences may simply be due to our differing aims in using qualitative content analysis, primarily her interest with the frequency of codes, contrasted with my interest in the themes and patterns within and between codes. While I realized during the early stages of coding that the framework by Lopez et al. (2012) would be most useful as an organizational tool for my codes, as further use was not compatible with my objectives, it appears that they remained suitable for Folmo (2014) and hence they have used broader themes of 'Clinical aspects', 'Interpersonal aspects', and 'Organizational aspects'. Due to the differing foci and coding approach it is therefore difficult to further compare our findings except in more general ways. For instance as a final note, from their quantitative analysis of the reviewers' star-ratings, Folmo (2014) found that communication and trust were stronger drivers of satisfaction than issues relating to service and availability (p. 57), which was also my impression from the themes and focus of my sampled reviews.

The other main point of comparison in the Norwegian setting is with the national patient experience studies conducted by the Norwegian Knowledge Center for the Health Services. While these studies have thus far focused on patient experience of hospital services, similar surveys focused on quality in primary care have been recommended in recent publications (Lindahl & Bakke, 2010). As discussed in the theory and existing literature section of this

paper, the results from such studies of patient experiences at somatic hospitals may not be entirely applicable to the primary care setting. A number of factors do overlap though, namely those regarding interpersonal factors relating to various staff and general informational and organisational matters.

Surveys such as those undertaken by the Norwegian Knowledge Center for the Health Services differ from my own study in a number of ways, with the two methods offering different information and insight. First and foremost, these national surveys are undertaken on such a large scale that it is possible to capture a wide section of the population, resulting in increased representativeness and generalizability which I was not able to achieve due to the scale of my study. Secondly, the official nature of the national surveys may affect the content of the reviews themselves – in contrast, Legelisten.no offers an informal, public, and somewhat interactive forum, which could allow for greater freedom in response. On the other hand, the reviewers on the website must also be aware that their comments can be seen by anyone, even the GP they review, and this may have both positive and negative effects.

Thirdly, the different format might have an impact on the results, particularly in terms of the patients who choose to participate. Web questionnaires often report higher response rates than traditional pen-and-paper surveys, as well as being roughly half the cost – however when given the choice between paper and web-based, some studies show that the majority of people prefer to return the completed paper version (Hohwü et al., 2013). And while Norway in particular is highly advanced technologically, it is likely that there would be some bias against older participants simply because of the online format. For instance, Folmo (2014) reported the underrepresentation of individuals over 60 years of age on Legelisten.no. I would also suggest that there could be some differences between paper and computer-based surveys in the length of free-text comments.

Furthermore, in the national surveys on patient experience the open-ended questions allowing for free-text comments come at the end of dozens of close-ended questions. These preceding questions could have a number of effects, perhaps dependent on the individual. For example, they might provide the respondent with a wide range of relevant factors to think about and spark a comment regarding one of these issues in the open-ended section. For others respondents, these preceding questions might exhaust them to some extent – particularly given the repetition of the five-point rating scale – and could also make them feel that they have already covered a number of issues and do not need to elaborate on them. In a similar

vein, the national surveys are more structured and comprehensive than any feedback form on a PRW.

And lastly, one of the biggest differences may be simply that the reviews from Legelisten.no depend on patients actively seeking out the website and choosing to write or read reviews. While participation in the national surveys is voluntary, the responses are solicited, unlike the reviews on PRWs. The survey's use of postal reminders to potential participants compounds this.

As a final, wider point of comparison, almost all of the previous studies on online GP reviews and PRWs – both in general and as specifically cited in this thesis – come from countries other than Norway, most often from the US. The themes and issues featured in the sampled reviews of this study were generally consistent with those identified in previous studies from abroad, as well as with the relevant theories discussed at the beginning of the study. Even if studies indicate that Norwegian patients may be less satisfied with their healthcare system than patients from comparable countries (Davis, Stremikis, Schoen, & Squires, 2014), the prominent themes raised in the sampled reviews of this study suggest that Norwegian patients want roughly the same things from their GP as patients do elsewhere. However, it is not within the scope of the study to draw conclusions on the matter.

5.5 Recommendations and other considerations

As governments in countries such as the UK and the US continue to develop official PRWs, one must consider whether such an initiative could be beneficial in Norway. This is particularly relevant given that GPs in Norway are employed through contract by the municipalities, but as yet municipalities do not have a direct way to measure the quality of work of their employed GPs (Ringard et al., 2013).

However, more research needs to be done on the motivation and demographics of patients who voluntarily seek out PRWs and review their past or present GP online, both internationally and in the Norwegian context. The study this year on the use of PRWs among German patients suggests that psychographic variables may be a more important factor than sociodemographics in terms of who uses PRWs and why (Terlutter et al., 2014). Similar insight into the users of Legelisten.no would be extremely helpful, particularly in assessing how feedback from the site can be used.

Even within the current limitations, however, I would argue that there remains potential merit in the development of a Norwegian version of the UK's NHS Choices website, an official PRW. While Legelisten.no as it stands provides a valuable forum for current and prospective patients, a successful government alternative could offer additional insight by including a few key questions on demographic and psychographic variables (with perhaps some extra comfort for patients in knowing that their answers would not be controlled by a private company). Furthermore, the contribution of government resources has the potential to offer increased capabilities and functionalities to a Norwegian PRW, especially given that Legelisten.no is currently a non-profit, advertisement-free website. If in the future the website introduces a paywall – which is not an uncommon path for formerly free websites and applications – this would obviously reduce accessibility significantly. It may therefore be worth it to assess the possibility of a similar government initiative with guaranteed freedom of access.

PRWs such as Legelisten.no may be particularly important as a complementary source of patient feedback given the unique and revealing nature of unsolicited free-text comments, in contrast to numerical scales or star-ratings. While quantitative measurements of experience and satisfaction are often a necessary complement to free-text comments, the difference in the results of the two measurement techniques may be significant enough that future surveys could explore different means of incorporating more qualitative reports alongside rating-scales. As B. Williams (1994) notes, “quantitatively measured expressions of satisfaction tends to be high, while qualitative reports reveal greater levels of disquiet” (p. 514). Similarly, Iversen, Bjertnæs and Skudal (2014) note that quantitative studies have been shown to overestimate patient satisfaction and experiences – which makes their note on the comparative lack of scientific guidance for free-text comments all the more unfortunate. Clearly, this is an area which requires further refinement and investigation, especially given the unique nature of the feedback which can be attained through such methods.

6 Conclusion

Given the very recent introduction of Legelisten.no, our knowledge of PRWs in a Norwegian setting is still lacking. This study attempted to address this lack in a small way by investigating the aspects of primary care that are important to Norwegian patients writing reviews of their GPs online, and what we can learn from how they are discussed in the reviewers' own words. For the most part, the findings support the existing literature focused on PRWs and patient experience and satisfaction from other countries. That is, patients place most importance on the interpersonal skills and perceived technical competence of their GP, over and above system or organizational aspects. In addition, a number of interesting and sometimes unexpected themes emerged from the data, including the GPs' specific competence in handling mental illness, and the prevalence of doctor-shopping behaviours. The unique format of PRWs, where every review is free-text, public, and unsolicited, was also evident.

The study is limited by the fact that we do not yet know if Legelisten.no's users are representative of the wider Norwegian population. Further research on Norway's first PRW and its users would be beneficial to uncover the full potential for its role as an alternative method of gathering patient feedback for GPs. If nothing else, the findings of this study may help to demonstrate the insight available from patient reviews on PRWs, and to indicate potential areas of interest for further research into patients' experiences, priorities, and satisfaction levels regarding primary care services in Norway.

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